Continuum of Care Action Team

John Chianelli
john.chianelli@mcfi.net
Mary Neubauer
maryneubauer@aol.com
Co-Chairs

SMART Goals

Improve the **coordination and flexibility of funding** committed to mental health services

- Establish Resource Strategy Team comprised of finance experts from foundations, private hospital systems, Milwaukee County, State of Wisconsin & the Public Policy Forum.
- Publish a report on mental health redesign financing for dissemination & discussion by stakeholders.
- Designate the Continuum of Care Action Team or form a new CRS Planning Workgroup to advise Milwaukee County on the design of CRS.
- Conduct a review of program & fiscal data to inform development of the CRS implementation plan.
- Submit CRS implementation plan to the Milw. Co. Board of Supervisors for review & approval.

Improve **crisis access & response** to reduce Emergency Detentions

- Develop a partnership between the Redesign Task Force and the current implementation process for developing an integrated, welcoming, crisis continuum of care.
- Support the increased utilization of person-centered crisis plans for the prevention of, and early intervention in, crisis situations through training and technical assistance provided County-wide.
- Prioritize expansion and responsiveness of mobile crisis services as well as other community crisis diversion services including walk-in services, clubhouse, and crisis bed options of all types.
- Facilitate earlier access to assistance for crisis situations for individuals & families through improved public information on how to access the range of crisis intervention services in the community.
- Improve the capacity of law enforcement to effectively intervene in crisis situations through expanded Crisis Intervention Team training.
- Improve policies & procedures related to crisis response in contracted services to reduce the likelihood that crisis events lead to emergency detention.

Improve the flexible availability and continuity of **community-based recovery supports**

- Develop & implement a mechanism for flexible utilization management that supports individualized matching of service intensity with the continuum of case management and other recovery supports.
- Develop & implement procedures to move from higher to lower levels of support (and conversely) in response to changing circumstances (e.g., crisis).
- Organize a flexible continuum of recovery supports for eligible individuals through CRS & CCS.
- Establish metrics to assess the financial and program impacts of this approach.

Comments, Suggestions, Questions?

Write anywhere.

Relevant Progress

Sustained expansion of Targeted Case Management

Community Recovery Services approval & implementation

Comprehensive Community Services implementation anticipated mid-2014

Establishment of new Recovery TCM level of case management

Continuum of Care Action Team (continued)

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SMART Goals

Improve **community transitions** after psychiatric hospital admission

- Establish a flexible, community-based continuum of care both formal services and informal supports.
- Maintain and strengthen crisis prevention, intervention, and diversion services in the community.
- Establish a partnership between Redesign Task Force efforts and existing discharge and transition planning improvement activities at the Behavioral Health Division and private hospital partners.
- Work in partnership with inpatient, crisis, community, housing, and peer support providers to develop and implement an improvement plan for facilitating transitions from any hospital in the County.
- Develop and implement a plan to track 90-day readmission data for all hospital partners.

Improve the **economic security** of persons with mental illness by increasing utilization of disability-related benefits

- Establish a baseline for the number of persons who received assistance with SSI/SSDI applications.
- Establish a baseline for the number of persons whose SSI/SSDI applications are approved.
- Develop a partnership involving the SSA, benefits counseling programs, SOAR trainers, Protective Payee providers, and persons with lived experience to develop, pilot, and implement a plan to improve access to application assistance.
- Increase access to recovery-oriented Protective Payee services for people needing this service.

Improve access to **non-hospital crisis intervention and diversion** services to reduce the number of people who experience acute hospital admissions for mental health crises.

- Implement Tactical Objectives in Goals 8 (crisis access & response), 9 (community-based recovery supports), 10 (community transitions), 13 (supportive housing), and 14 (reduce incarceration).
- Involve all types of providers in the partnership to reduce admissions including crisis services, day treatment, peer support, clubhouse, case management, and informal community supports.
- Improve policies, procedures, and practices that facilitate early access to crisis intervention by providers and law enforcement, continuity of care, diversion from hospitalization into CRCs, and rapid step-down from hospitalization into intermediate levels of support.
- Develop a County-wide mechanism for triaging availability and flow between high and lower systems of care.
- Develop a plan for collecting baseline data and tracking hospital diversion and utilization percentages across the County.

Comments, Suggestions, Questions?

Write anywhere.

Relevant Progress

Collaboration with MPD to train and assign an officer to join the Crisis Mobile Team

Increase in person-centered crisis plans on file for BHD Crisis Services consumers

RFPs in progress for Peer-Run Drop-In Center, additional Access Clinic (south side), and expanded hours for mobile crisis response